SARA RIEL INC.
APPLICATION FORM

Please complete the application form completely so we may assist you to receive service in Housing, Community Supports and Employment. The contact information is at the end of the application. Please call should you require any assistance.

Please identify referral source (leave blank if self referral)

REFERRAL SOURCE
Name ______________________________ **Title** ____

Organization/Agency____
Address __________________________ **Postal Code** ______________

Phone (   ) _____________________ **Fax number (   )** _________________ **E-Mail** __________________

Individual to complete all of the following information:

CLIENT DATA
Name ________________________________ Phone ____________________e-mail ________________
Address ______________________City______________ Prov. ______________Postal Code ____________
At this address since: _____________ Rent amount $ _______________ At this address until _____________
Landlord Name ______________________Address ________________________ Phone __________________
Date of Birth ____
Sex: Male _____ Female ____ Transgendered ______
MHSC # ____________________________ PHIN# ___________________________________
Treaty # ___________________________ EIA # _____________________________________

EMERGENCY Contact Name_____________________________ Phone___________
Address ____
Relationship ____
Marital Status _________________________________ Employment Status ___________________________
Dependants ____________________________________ Are they in your care? Yes / No
If no, where do they reside? ____

ALLERGIES
Please list all allergies and treatments
____
____

MEDICAL CONCERNS
Please list all medical diagnoses, physical limitations or concerns
____
____

Treatments
____
____

FINANCIAL
Source of income:
- ❒ Employment and Income Assistance
- ❒ Self Supporting
- ❒ Disability (CPP, Private, Disability)
- ❒ Employment Insurance
- ❒ Other

PROFESSIONALS INVOLVED

PSYCHIATRIST ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

PHYSICIAN ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

COMMUNITY MENTAL HEALTH WORKER ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

EMPLOYMENT and INCOME ASSISTANCE WORKER ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

VOCATIONAL REHABILITATION WORKER ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

FINANCIAL WORKER ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

OTHER SUPPORTS

FAMILY ______________________ Relationship ______________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

FAMILY ______________________ Relationship ______________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

OTHER ______________________________
Address ____________ City ____________ Prov ________ Postal Code ________
Phone __________ Cell ____________ Fax ____________ e-mail ____________

EDUCATION
Highest level of education:

- ❒ Elementary
- ❒ High school
- ❒ University undergraduate
- ❒ University graduate
- ❒ Community college
- ❒ Other

Are you interested in furthering your education? Yes / No
Explain____
____

LITERACY

Do you have difficulty reading? Yes / No
Do you have difficulty writing? Yes / No
What is your chosen language for service delivery? ____________________

CURRENT LIVING SITUATION

- ❒ Alone
- ❒ Roommate
- ❒ Spouse
- ❒ Children
- ❒ Parents / Grandparents
- ❒ Group home
- ❒ Supervised living
- ❒ Hotel
- ❒ Homeless
- ❒ Other

Have you ever lived on your own? Yes / No

CRIMINAL JUSTICE

Do you have a criminal record? Yes / No
Explain: ____________________

Do you have charges pending? Yes / No
Explain: ____________________

Are there any legal orders or probation orders that we need to be aware of? Yes / No
Explain: ____________________

AGGRESSION

Have there ever been any situations of aggression toward others by you? Yes / No

- ❒ Physical
- ❒ Verbal
- ❒ Intimidation
- ❒ Weapons
- ❒ Court orders
- ❒ Restraining orders

SUICIDE / SELF HARM

Have you ever attempted suicide? Yes / No When ?____________________
Explain:
____

Have you ever engaged in self-harm? Yes / No When? ____________________
Explain:
____

ADDICTIONS

Have you ever had involvement with the following?

	Past Concern(past 5 Years)	Current Concern
Alcohol	______	______
Gambling	______	______
Illegal drugs	______	______
Prescription drugs	______	______
Non-prescription drugs	______	______
Solvents	______	______
Other	______	______

What problems have these issues caused in your life?

- ❒ Relationship problems
- ❒ Financial problems
- ❒ Legal problems
- ❒ Obligations at home
- ❒ Stealing/Theft
- ❒ Eviction/Property damage
- ❒ Participation in unusual behaviours
- ❒ Weight loss or gain
- ❒ School/employment
- ❒ Involvement with gangs

Other ___________

COGNITIVE

Do you have difficulty in any of the following area(s)?

- ❒ Memory
- ❒ Concentration
- ❒ Decision making
- ❒ Problem solving

Do you want to make it a personal goal to address any of these issues? Yes / No

SUPPORT NEEDS

Do you want to make it a personal goal to work on?

Counseling areas:

- ❒ Anger management
- ❒ Education
- ❒ Psychiatric concern
- ❒ Coping
- ❒ Addictions
- ❒ Medication
- ❒ Crisis intervention
- ❒ Suicide
- ❒ Family
- ❒ Self-Esteem
- ❒ Sexuality
- ❒ Abuse
- ❒ Legal
- ❒ Grief and loss

Life Skills areas:

- ❒ Finding and getting housing
- ❒ Keeping housing
- ❒ Housekeeping
- ❒ Laundry
- ❒ Physical needs
- ❒ Transportation
- ❒ Communication
- ❒ Nutrition
- ❒ Social networking
- ❒ Spirituality
- ❒ Personal self care

Employment

- ❒ Finding work
- ❒ Preparing to find work
- Maintenance of employment/Keeping your job

PSYCHIATRIC

Do you have a psychiatric diagnosis?

- ❒ Schizophrenia
- ❒ Anxiety disorder
- ❒ Bi Polar
- ❒ Depression
- ❒ Learning disability
- ❒ Social phobia
- ❒ Panic disorder
- ❒ Obsessive compulsive disorder
- ❒ Personality disorder
- ❒ Post traumatic stress disorder
- ❒ None
- ❒ Other

If other, please explain: ____

MEDICATIONS
Please list all medication(s) you are currently prescribed:

Medication

1.	5.	9.
2.	6.	10.
3.	7.	
4.	8.	

Are there any issues with medication compliance? Yes / No

Explain: ____

Are there any risks with this medication we should be aware of? Yes / No

Explain: ____

Have you had any medication changes in the last six months? Yes / No

Explain: ____

HOSPITAL ADMISSIONS/ CRISIS UNIT STAYS
Have you ever been admitted to a psychiatric hospital? Yes / No

Please indicate:

- ❒ Never hospitalized
- ❒ Last stay less than one month
- ❒ Last stay 1-3 months ago
- ❒ Last stay 4-6 months ago
- ❒ Last stay more than 6 months ago

If hospitalized indicate the total number of times

- ❒ Once
- ❒ Two to four times
- ❒ Five or more times

Where was your most recent place of hospitalization? ____

Date ____________________________________
Describe the symptoms

____

____

Have you ever used the Crisis Stabilization Unit? Yes / No
Have you ever called the Mobile Crisis Team? Yes / No

STRENGTHS:
Please identify your strengths

____
____
____
____
____

PLEASE PROVIDE A HISTORY OF ANY ASSESSMENTS AVAILABLE TO ASSIST IN PROCESSING THIS APPLICATION

IF INTERESTED IN THE HOUSING AND COMMUNITY SUPPORT PROGRAM, PLEASE COMPLETE

I, ______________________________________ am in agreement that this referral form is complete and accurate.

Signature ____ Date ______________________________________

If interested in Employment please complete information below

****************Please attach a copy of your resume*****************

Area of job search you would like to improve upon:

- ❒ Resume writing
- ❒ Interview strategies
- ❒ Finding job leads
- ❒ Handling rejection
- ❒ Self presentation
- ❒ Improve confidence
- ❒ Telephone skills
- ❒ Awareness of strengths and weaknesses
- ❒ Employers expectations
- ❒ Other

Previous / current employment programs involved with:

- ❒ Employment Insurance sponsored
- ❒ Employment and Income Assistance sponsored
- ❒ Other
- ❒ Employment Dimensions (CMHA)
- ❒ SSCOPE
- ❒ Sair Center
- ❒ Clubhouse
- ❒ Vocational rehabilitation

Explain: ____

What was your last paid employment? ____

What is preventing you from getting work? ____

What are your employment goals? ____
____

REFERRAL SOURCE

Are you referring yourself? Yes / No

If yes, where did you learn about the Work Placement Force at Sara Riel Inc.? ____________________

If no, who referred you? ____

I ______________________________ am in agreement that this referral form is complete and accurate.

Client Signature ________________________________ Date ___________________________

All applications should be sent to: **smartens@sararielinc.com**
Phone (204) 237-9263 Ext 49
Fax (204) 233-2564

Mailing Address:
Sara Riel Inc.
210 Kenny Street
Winnipeg, MB R2H 2E4

Authorization for Release of Information
For Sara Riel to share with others

I am of the age of majority and hereby authorize Sara Riel Inc. to share my private and or financial information as necessary in application for the provision of mental health, skill development and or employment related services. I understand my information will be shared by all staff providing support to me through any department within Sara Riel Inc. as is required to provide these supports.

Name ___________________________________ Date of Birth ____________________

I understand that Sara Riel Inc must share certain information with other program funding sources and the Winnipeg Regional Health Authority in an ongoing provision of services as required in the individual funding contracts.
I understand that there are certain specific instances when my confidential information may be shared with other service providers as follows:

- In the case where my Sara Riel service provider has justifiable reason to believe that maintaining confidentiality may result in serious threat to the health and safety of me and /or another person, the proper emergency services may be contacted.
- If I am ill, incapacitated and am unable to provide information required to receive care.

I release Sara Riel Inc, its employees, agents, students, researchers and volunteers from any and all claims whatsoever which may arise as a result of the release of information. I understand that Sara Riel staff are bound by confidentiality agreements as part of their condition of employment and may only use my information to provide services to me as I have agreed (List all areas the client is open to receive services).

Community Supports ________________
    Case Management / Social Work _____
    Mental Health Supports ____________
Housing Supports ___________________
Employment ________________________

Dated this __________________ day of ____________________, 20 ____

Client Signature _____________________ Print Name ________________

Witness Signature ____________________ Print Name _____________

Authorization for Release of information
For Others to Share with Sara Riel Inc.

I am the full age of majority and hereby authorize that Sara Riel Inc. may receive my private health, social and psychological assessments and financial information as necessary in my application to Sara Riel Inc. for services. I authorize the release of information regarding my files from the following organizations for the purpose of receiving supports from Sara Riel Inc. (admission summaries, discharge summaries and progress notes)

Name ______________________________ Date of Birth ______________________

Please check off the areas required and name the contact person or agency

- ❒ Employment and Income Assistance ________________________________
- ❒ Psychiatry____
- ❒ Physician ____
- ❒ Public trustee ____
- ❒ Community Mental Health ____
- ❒ Family ____
- ❒ Pharmacist ____
- ❒ Hospital ____
- ❒ Crisis Stabilization Unit ____
- ❒ Mobile Crisis Services ____
- ❒ Canada Pension Plan ____
- ❒ _____________________ ____
- ❒ _____________________ ____

I understand that I may revoke my authorization to share my private information with any and all of the above at any time by way of written notice of change.

I understand that Sara Riel Inc must share certain information with the Government of Manitoba and Winnipeg Regional Health Authority in the ongoing provision of services.

I understand that there are certain specific instances when my confidential information may be shared with other service providers as follows:

- In the case where my Sara Riel service provider has justifiable reason to believe that maintaining confidentiality may result in serious threat to the health and safety of myself and /or another person, the proper emergency services may be contacted.
- If I am ill, incapacitated and am unable to provide information required to receive care.

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Community Supports ________________

Case Management / Social Work _____

Mental Health Supports ____________

Housing supports ___________________

Employment _______________________

Dated this _________________ day of ___________________, 20 ____

Client Signature ____________________ Print Name ________________

Witness Signature ___________________ Print Name ________________

Authorization for Release of information
For Sara Riel Inc. to share with others

I am the full age of majority and hereby authorize that Sara Riel Inc. may share my private health, social and psychological assessments and financial information as necessary in my application to Sara Riel Inc. for services. I authorize the release of information regarding my files at Sara Riel Inc to the following organizations for the purpose of receiving supports from Sara Riel Inc.
Name ______________________________ Date of Birth ______________________
Please check off the areas required and name the contact person or agency

- ❐ Employment and Income Assistance ________________________________
- ❐ Psychiatry____
- ❐ Physician ____
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- ❐ Family ____
- ❐ Pharmacist ____
- ❐ Hospital ____
- ❐ Crisis stabilization Unit ____
- ❐ Mobile Crisis Services ____
- ❐ Canada Pension Plan ____
- ❐ ______________________ ____
- ❐ ______________________ ____

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Community Supports ________________
Case Management / Social Work _____
Mental Health Supports ____________
Housing supports ___________________
Employment _______________________

Dated this _________________ day of ___________________, 20 ____

Client Signature ____________________ Print Name ________________

Witness Signature ___________________ Print Name ________________